

## Funguria

Relatively common

Organisms

Candida albicans	50%
Candida glabrata	10 – 15%
Others	35 – 40%

Risk factors

Diabetes  
Immunosuppression  
Indwelling urethral catheters  
Antibiotics  
Hospitalisation

Presentation

### Asymptomatic

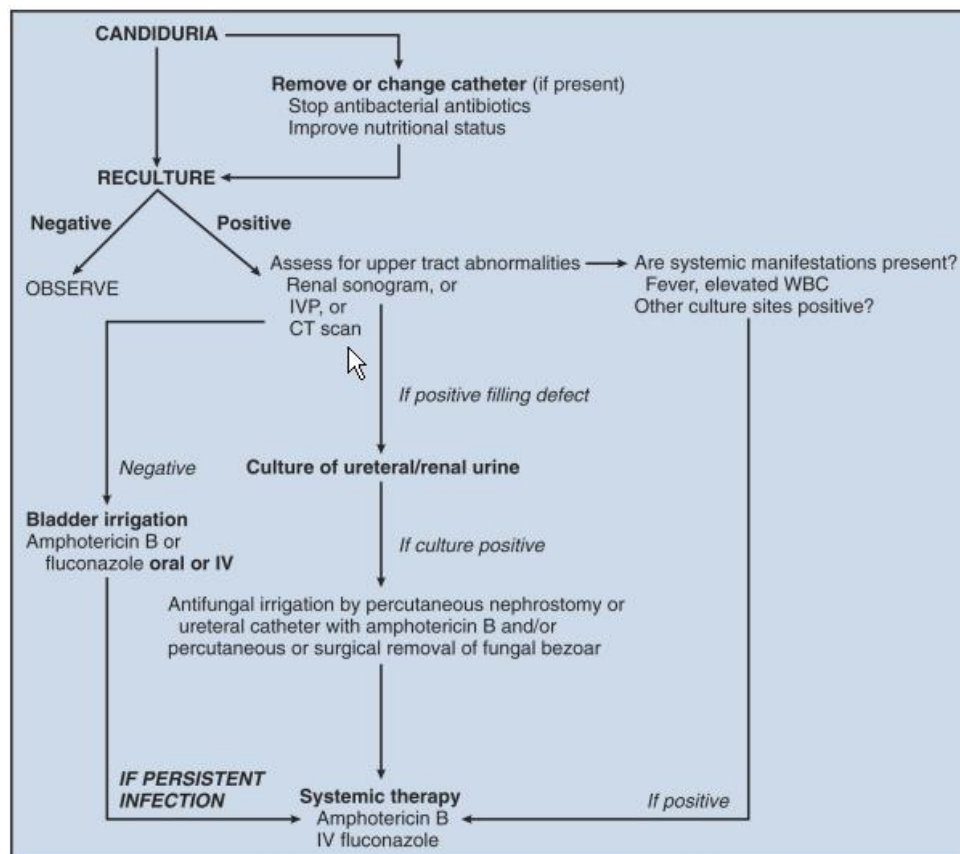
Dysuria and storage LUTS                      invasive LUT infection  
Fever loin pain and chills                      invasive UUT infection  
Obstruction    fungal bezoar

Diagnosis

Numbers of cfu/ml undefined – **any positive urine culture should be evaluated**

Presence or absence of pyuria irrelevant

Management



Majority of patients with asymptomatic funguria do not require antibiotic therapy: ~ 75% patients clear fungus following catheter change, cessation of antibiotics and attention to glucosuria. Other considerations:

- (i) Persistent funguria with normal upper tracts
  - a) Intravesical Rx
    - 50mg amphotericin B in 1L water via three-way catheter over 24 hours (IVAC 40 ml/h)
  - b) Oral Rx
    - Fluconazole 200mg/day for first day; 100mg day thereafter for 14 days. SE N+V, abdo pain and diarrhoea
- (ii) Renal and disseminated candidiasis
  - a) Intravenous fluconazole or amphotericin B
    - APB a/w significant SE when given IV – chills, rigors, fever, bone marrow toxicity
- (iii) Fungal bezoar
  - a) Nephrostomy and irrigation with antifungals
  - b) Percutaneous removal (Amplatz sheath)
  - c) Nephrectomy